

The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th Floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

INITIAL DENTAL ASSISTANT LICENSURE
(See 234 CMR 4.11 and 4.12 Effective October 10, 2014)

Applicant Instructions

The Board may grant a license to an applicant provided the applicant is at least 18 years of age, of good moral character, has met all of the eligibility requirements, and has submitted the necessary information and documentation to the Board. Please note additional specific documents or information will be required as determined by the category of dental assistant licensure indicated: **On-The-Job Trained, Formally-Trained, Certified or Expanded Function.**

ALL applicants must submit the following documents:

- An accurate, complete and signed application including CORI request form;
- Payment of a nonrefundable, nontransferable licensing fee;
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS);
- An attestation, signed under the pains and penalties of perjury, that the applicant has obtained, within one year prior to the date of application, a written statement from a physician, nurse practitioner or physician assistant attesting to the applicant's health and fitness to practice dental assisting, which applicant shall make available to the Board upon request;
- An attestation, signed under the pains and penalties of perjury, that the applicant has read, understands and agrees to comply with *The Policy on Principles of Ethics and Code of Professional Conduct*, published by the American Dental Assistants Association;
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dental assisting, dental hygiene or dentistry attesting to the standing of his/her license, including a report of any past or pending disciplinary action, or any pending complaints against the applicant;
- A passport-sized (2x2) color photograph;
- A statement disclosing any disciplinary, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation (including certified copies of court document(s) pertaining to any out-of-state criminal action) as may be required by the Board;

- An attestation, signed under the pains and penalties of perjury, that the applicant has complied with all state tax laws pursuant to M.G.L. c.62C, §49A and child support laws pursuant to M.G.L. c. 119A, §16(a); and
- Proof satisfactory to the Board of good moral character.

Please see the following categories of dental assistant licensure for the list of additional information or documents required to be submitted with the application for licensure:

On-The-Job Trained:

- Submission of the name and Massachusetts license number of the applicant's supervising dentist (*NOTE: the applicant's supervising dentist must confirm his/her supervision of the applicant through the online process before the application will be considered complete*);
- Documentation of a completed course on the CDC Guidelines for Infection Control in Dental Health-Care Settings;
- If applicable, proof of successful completion of a course in radiological techniques and safeguards or proof of successful completion of the DANB Radiation Health and Safety Examination or the Massachusetts Dental Society Dental Radiology Examination within one year of completion of the course; and
- Documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English language proficiency (such as the TOEFL exam) if the applicant has previously received on-the-job training in a language other than English.

Formally-Trained, Certified and/or Expanded Function:

- Documentation demonstrating successful completion of a dental assisting program as follows:
 1. Proof of current certification from DANB or other Board-approved certifying body; or
 2. An original transcript including the date of graduation and degree accredited, licensed or certified by the Massachusetts Department of Higher Education (DHE), or the New England Association of Schools and Colleges (NEASC) or both; or
 3. An original transcript including the date of graduation and degree granted from a CODA-accredited, Chapters 69 and 74 Approved Program in dental assisting; or
 4. An original transcript including the date of graduation or a letter including the school or program's seal which is signed by the appropriate authority and attests to the applicant's degree, diploma or certificate from either a Chapters 69 and 74 Approved Program in dental assisting or a Chapter 112 Approved Program in dental assisting, provided that such program meets the criteria set forth at 234 CMR 4.10; or
 5. Such proof of completion of a Chapter 112 Approved Program in dental assisting, as the Board may declare to be acceptable via an advisory ruling, provided that such program meets the criteria set forth at 234 CMR 4.10; and
- Documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English language proficiency (such as the TOEFL exam) if the applicant graduated from a dental assistant school or program where the

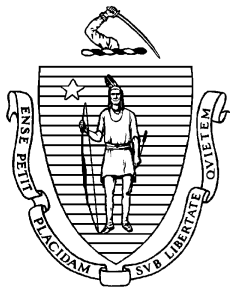
language of written or oral instruction (including textbooks) or both, was in a language other than English.

Please Note:

- Incomplete applications will delay licensure processing.
- Please retain a copy of all application submissions for your records.
- Confirmation of your license number will be available under “Online Services/Check a License” on our website www.mass.gov/dph/boards/dn as soon as the Board approves the license.

Notice of Intent to Apply as a First-Time Dental Assistant Trained On-The-Job (234 CMR 4.13):

- A person who is at least 18 years of age, who has not been previously licensed or registered as a dentist, dental hygienist or dental assistant and who is not in violation of any rule or regulation adopted by the Board may practice as a dental assistant under the supervision of a licensed dentist without being registered by the Board for a preliminary and one-time period of up to six consecutive months to commence from the beginning of the initial period of on-the-job training.
- Prior to the commencement of the unlicensed on-the-job training, the person notifying the Board of his or her intent shall provide written notification of the intent to commence training on a form prescribed by the Board and shall submit the following documentation to the Board:
 1. A complete, accurate, signed, and notarized notice of intent;
 2. Attestation that the person named in the notice of intent has never practiced or been licensed as a dentist, dental hygienist or dental assistant;
 3. Submission of the name and Massachusetts license number of the supervising dentist including verification by the supervising dentist the applicant has completed a course on the CDC Guidelines for Infection Control in Dental Health-Care Settings; and
 4. Date when the six-month unlicensed on-the-job training will commence.
- Upon receipt of a written request, the Board may extend the on-the-job training period for up to an additional six months for a dental assistant who is enrolled in a program of professional educational training for dental assistants offered by a college, university or dental school authorized to confer degrees or by another dental institution or association recognized by the Board. The written request must include:
 1. Name and signature of the supervising dentist responsible for the on-the-job training of the dental assistant; and
 2. Proof satisfactory to the Board of the on-the-job trained dental assistant’s enrollment in a dental assisting program that meets the requirements for licensure pursuant to 234 CMR 4.11(3).



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BOARD USE ONLY

Receipt # _____

Fee : _____

**APPLICATION FOR INITIAL
DENTAL ASSISTANT LICENSURE**

1. APPLICANT NAME: _____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME: _____

3. ADDRESS OF RECORD: _____
(No.) (Street) (Apt #)

(City/Town) (State or Country) (Zip/Postal Code)

Note: The address of record may be a home or a business address and is considered public information.

4. TELEPHONE NUMBER AND EMAIL ADDRESS: Day: _____ Cell: _____

Email address: _____

5. ____/____/____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: ____ Feet ____ Inches WEIGHT: ____ Lbs. MOTHER'S MAIDEN NAME: _____

6. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):** ____/____/____

Pursuant to M.G.L. c. 62C, §47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, §47A) and child support laws (M.G.L. c. 119A, §16).

EDUCATION

7. GRADUATE OF: _____
Name of Dental Assistant School/Program City, State, Zip Code

8. DATE DIPLOMA OR CERTIFICATE CONFERRED MM/DD/YR _____ DEGREE _____

AN OFFICIAL TRANSCRIPT OR ORIGINAL LETTER FROM THE DEAN'S OFFICE CONFIRMING THE ABOVE INFORMATION MUST BE ATTACHED.

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

9. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS INCLUDING PROFESSIONS OTHER THAN DENTAL ASSISTING WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION

☐ I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:

<u>Issuing Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES AND ALL RELEVANT DOCUMENTATION INCLUDING FINAL DISPOSITION.

10. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

11. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

12. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

13. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$100 or less was imposed.

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a dental assistant I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed dental assistant in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a dental assistant shall be deemed no longer valid if requirements for licensure as a dental assistant not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that I:

- Have read, understand and agree to comply with *The Policy on Principles and Ethics and Code of Professional Conduct*, published by the American Dental Assistants Association; and
- Have obtained, within one prior to the date of this application, a written statement from a physician, nurse practitioner or physician assistant that I am in good health and fit to practice dental assisting.

I also certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license, to suspend or revoke a license issued to me, and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

TO BE COMPLETED, SIGNED AND WITNESSED BY THE APPLICANT AND A NOTARY PUBLIC.

APPLICANT SIGNATURE _____

DATE _____

PRINT NAME _____

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal or stamp]

**DO NOT FORGET TO INCLUDE THE NON-REFUNDABLE, NON-TRANSFERABLE FEE OF \$60.00
(CHECK OR MONEY ORDER ONLY) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**

**Attach a recent color
2x2 passport
photo**

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER

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KARYN E. POLITO

Lieutenant Governor

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www.mass.gov/dph/boards/dn

MARYLOU SUDDERS

Secretary

MONICA BHAREL, MD, MPH

Commissioner

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

**TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT,
VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.**

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a BHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____-_____

Sex: ____ Height: ____ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Mother's Full Name (Mother's Maiden Name)

Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: _____ ON _____
Name of Verifying BHPL Employee or Notary Public (Please Print) Date

Signature of Verifying BHPL Employee or Notary Public

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal or stamp]

September 2016